Evolving service interventions in Nunhead and Norwood

PRiSM Psychosis Study 2

THOMAS BECKER, FRANK HOLLOWAY, PAUL McCRONE and GRAHAM THORNICROFT

Background Service evaluation requires a detailed understanding of the services studied.

Method Community mental health services evaluated in the PRiSM Psychosis Study in south London are described. The intensive sector and standard sector services are contrasted.

Results The intensive sector had two teams with extended opening hours: a psychiatric acute care and emergency (PACE) team, and a psychiatric assertive continuing care (PACT) team focusing on care for people with chronic illness. In the standard sector there was a generic community team providing office-hour assessments, case management of the severely mentally ill and close liaison with in-patient services. The team made use of the local psychiatric emergency clinic and of other local resources. The intensive sector was characterised by: more admissions to fewer beds, more non-hospital residential places, extended hours, on-call rota, wider range of interventions, more medical and nursing staff, a lower nursing grade mix and higher staff turnover. The standard sector had a less highly resourced generic community psychiatric service.

Conclusions Change in services has been more marked in the intensive sector.

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The PRiSM Psychosis Study compares two different types of community mental health services by means of a longitudinal follow-up of a representative sample of patients with psychotic disorders in two sectors in south London with similar socio-demographic characteristics (see paper 1 in this series, Thornicroft *et al*, 1998, Table 1). This paper provides a description of the aspirations guiding the two teams, the implementation of services and their evolution over the study period. The terms 'intensive sector' and 'standard sector' will be used along with the respective sector names, that is Nunhead and Norwood, respectively.

ASPIRATIONS

The intensive sector team had a set of aspirations which have been outlined by Strathdee *et al* (1994*a*). These guiding principles draw on earlier documents (MIND, 1983; Royal College of Psychiatrists, 1990). There was an emphasis on home-based care, continuity of care, assertive outreach, non-hospital crisis services, and integration with the primary care services (Table 1; for full list of principles see Table 6). The aspirations guiding the standard team were more restricted and reflected Department of Health guidance over the study period.

INTENSIVE SECTOR IMPLEMENTATION

Pre-intervention services for the Nunhead population comprised acute wards, a day care and rehabilitation centre (with rehabilitation beds), a limited primary care-based community psychiatric nurse (CPN) service, work provision and supported housing. There was little social services input. Full sectorisation was achieved in August 1992. Table 2 summarises changes in Nunhead's mental health services from the pre-intervention period to the PRiSM Study's intervention phase. The Bethlem and Maudsley Hospitals first took on catchment area responsibility for South Southwark (of which the Nunhead area was part) in the late 1960s (Wing & Hailey, 1972). In 1991, before the study, South Southwark services comprised three 25-bed acute wards, a three-person primary care-based CPN team and a district services centre which offered a comprehensive in-patient, day-patient and out-patient service to some people in the area with severe mental illness. For South Southwark as a whole, there were 32 beds within the district services centre and 14 beds in a hospital hostel. A range of work-related and low-support housing provision had been developed under the aegis of the hospital. Two specialist teams (the Daily Living Programme and the Mobile Support and Treatment Team) offered experimental case management services to the local population. There were no specific geographical responsibilities within the catchment area. The intensive sector services were developed out of one-third of the total identified South Southwark resource.

Over the whole period of implementation of the intensive sector services there was no change in social services responsibility. One of the district services centre teams became in 1992 the psychiatric assertive continuing care team (PACT), but continued to operate from the district services centre site until 1994. The psychiatric acute care and emergency (PACE) team was set up in 1992 to provide cover 13 hours a day, seven days a week for crisis intervention, and a community respite house with an additional on-call rota.

Table 1 Intensive (Nunhead) and standard (Norwood) sector service aspirations

Nunhead
Acute home-based care
Decrease hospital admissions
Continuing care and assertive outreach
Non-hospital crisis and respite beds
Interagency and primary care liaison
Norwood
Generic community mental health team
Use of hospital as one service component
Use of local and other accessible resources

Table 2 Intensive sector (Nunhead) changes over time

Pre-intervention	Intervention phase
Non-sectorised	Sectorised
36 acute and rehabilitation beds	16 acute beds, 7 community respite beds[1]
District services centre[2] – day care	(PACE and) PACT team base
One community psychiatric nurse	18.8 community-based nursing and occupational therapy staff
More hospital-based staff	Fewer hospital-based staff
Emergency clinic[3] and consultant domiciliary visits	Emergency clinic, consultant domiciliary visits and home-based crisis intervention, extended hours
No GP liaison	Extensive GP liaison

1. Not staffed, i.e. not fully functioning.
2. Maudsley Hospital-based resource centre including wards.
3. Maudsley Hospital-based 24-hour staffed emergency clinic.
PACE, psychiatric acute care and emergency; PACT, psychiatric assertive continuing care; GP, general practitioner.

There were 25 acute hospital beds available, reduced to 12 in 1992 to provide the staff transfer to the PACE team, and then increased to 16 beds subsequently (in 1994). The agreement, within the Nunhead service, was for the PACT team to have access to four out of the total of 16 beds. In the previous arrangement there had been 11 non-acute district services centre beds and access to a local hostel. These were lost when the PACT team was formed. Under the new arrangements, the teams had access to respite residential services with staff availability for twice-daily visits (house A – three beds, house B – four beds). It was originally proposed to utilise a six-bed house as a crisis facility with staff based on site. However, the project was not forthcoming because of the extra staffing costs that would have been required. Joint case registers were implemented in 15 general practitioner (GP) surgeries, and out-patient clinics were being provided in some GP surgeries. Identification/liaison meetings were held with social services, police, housing and churches.

INTENSIVE SECTOR SERVICE COMPONENTS

The PACT team focused on the care of people with long-term mental illness, providing needs assessment and care plans, assertive outreach, home-based treatment, day care and rehabilitation facilities. The team worked extended hours (8 am–7 pm or 8 pm), with 24-hour telephone cover for PACT clients which included a call-out if that was indicated. The team moved to a spacious one-storey building on one of the sector's high streets in the course of the study (August 1994). This new site then became the joint Nunhead sector day site. The day site was used as a drop-in and offered structured daytime activities including occupational therapy and recreational activities. Domiciliary visits were part of the daily routine of the team's work, and the crisis/respite house would be used on an *ad hoc* basis with a member of staff visiting twice daily. There was a focus on users' physical health, housing and other social needs, and liaison with GPs, social services and voluntary sector providers was emphasised. In particular, considerable effort went into liaison with housing associations and other local providers of supported accommodation (Childs, 1995). The team engaged in a series of projects of training housing workers, church workers and local police in mental health, in dissemination and user involvement projects (Strathdee *et al*, 1994*b*). Staff estimated that 50–70% of their time was spent in home- or community-based treatments (daily living skills, engagement in community facilities, coordination of housing, welfare, adult education, medication monitoring, carer support, family education and liaison with GPs). A detailed description of the PACT team's work is given by Childs (1995).

The PACE team started its work in the latter part of 1992 and focused on the management of new referrals, assessment and home-based treatment, GP sessions and primary care liaison. There was an emphasis on coordination between the PACE team and the in-patient unit with an aim of keeping duration of hospital stays as short as possible. Crisis intervention and extended opening hours were part of the team's guiding principles. The daily routine included a morning hand-over meeting which reviewed any out-of-hours contact of PACE team clients with the Maudsley Emergency Clinic. The meeting which was chaired by the day's team coordinator received feedback from the team member on-call and reviewed people on the team's crisis list. A plan for the day was agreed upon for any person on the crisis list. At 5 pm the team member on-call received a hand-over. Team members were expected to spend the bulk of their working time doing home visits and liaison with carers, GPs, social services staff and voluntary sector (e.g. housing association) staff. A detailed information pack for GPs was developed.

A survey of 184 local GPs found that they desired rapid response on a daily 24-hour basis by crisis intervention outreach teams, assessment by experienced staff, outreach assessment and treatment of suicidal and parasuicidal people, and easily accessible approved social workers services (Strathdee, 1990). Individuals with mental disorders were referred to the intensive sector service from a total of 26 practices and 47 GPs. The core practices in the patch were two large fund-holding practices and five larger (four or more partners) group practices, the remainder comprising single-handed GPs or practices with small numbers of partners. This large number challenged the community teams to find methods of working closely with primary care counterparts. The system which was established has been described by Strathdee (1992). It included a directory of all statutory and voluntary sector mental health services in the area, that was produced and sent to all sector GPs (including treatment provided, likely treatment effects, and number of sessions); joint case registers of the long-term mentally ill in the practices; good practice protocols developed at the request of local GPs; identified link or liaison person for each practice; bids to obtain sessional attachments of a primary care counsellor, psychologists and mental health nurses; and six-monthly review meetings for patients on the Care Programme Approach with larger practices.

To fund relocation of services to the community the number of beds available for the sector (25 acute beds, 11 district services centre beds) was gradually reduced from 36 to 12 in the course of about 15 months (Strathdee *et al*, 1995). Subsequently the number of beds was adjusted

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Table 3 Standard sector (Norwood) changes over time

Pre-intervention	Intervention phase
Non-sectorised	Sectorised
19 acute beds	19 acute beds
Day hospital	Resource centre
3 community psychiatric nurses	7 community-based nursing and occupational therapy staff
Emergency clinic, consultant domiciliary visits	Emergency clinic, consultant domiciliary visits
No general practitioner liaison	Some general practitioner liaison

to 16. Two community houses were run jointly by the PACE and PACT teams, but their utilisation was hampered by the lack of sufficient staff so that the maximum intensity of care during most of the study was two domiciliary visits a day (Strathdee & Perry, 1997). PACE opening hours, in the course of the study, were reduced to 9 am to 5 pm, seven days a week. Within the PACE team there was a phase of major staff turnover and change in skill mix leading to more senior nursing staff in 1995/96. The PACT team moved to its community site in August 1994. This site was also used to provide day services for the whole sector. There were links with the South Southwark social service mental health team. Social service teams were sectorised during this period. There were local voluntary sector day service providers, supported housing schemes and residential provision by housing associations. There was some increase in private sector bed usage during 1995/96.

STANDARD SECTOR IMPLEMENTATION

Before the establishment of the 'standard sector', acute wards at a district general hospital, a psychiatric day hospital, secondary-care-based CPN service, work provision, supported housing and extensive social services resource were available to the local population. Full sectorisation was achieved in April 1994. Table 3 summarises changes in Norwood's mental health services from the pre-intervention period to the intervention phase. Psychiatric services for the Norwood sector were, until merger with the Maudsley Hospital in 1991, provided by Camberwell Health Authority. In-patient bed services for the Norwood sector population were of very poor quality and located at the Dulwich Hospital. Day care was provided by St Giles Day Hospital. Out-patient clinics and an effective community nursing service catered for the catchment area, of which Norwood represented 50% of the population. Lambeth social services provided a range of residential and day care services. Historically, spending by Lambeth social services on care for the severely mentally ill has been higher than in Southwark. Beds for Norwood sector patients were relocated to the Bethlem Royal and subsequently to the Maudsley Hospital. Number of beds were stable (at 19). Day care and community team members were based at St Giles Hospital, which was located outside the catchment area. A local team base within the catchment area was opened in early 1995.

STANDARD SECTOR SERVICE COMPONENTS

One generic community mental health team was based at a community mental health centre, and the sector team shared an independently staffed mental health resource centre operating as a day site and drop-in with a neighbouring sector mental health team. The Norwood sector community mental health team took referrals from a variety of sources, offering rapid but not immediate assessment either at the team base or at home as necessary. Intervention outside office hours was provided by the emergency clinic at the Maudsley Hospital. The community team was targeted towards people with a severe mental illness, with medical and psychology staff providing out-patient care treatment for those with less severe disabilities. There was very close liaison with the in-patient unit and an emphasis on the use of local generic resources and a sheltered work facility located adjacent to the team base. The community services were only available during standard office hours.

COMPARING THE SERVICES

Changes during the intervention phase in the intensive sector included sectorisation, reduction of beds, new community respite beds (not staffed), a drastic increase in the number of staff working wholly in the community (from one CPN to 18.8 whole-time equivalent nursing and occupational therapy staff), home-based crisis intervention, extended hours, on-call rota and extensive GP liaison. Resources for this change came from the pre-existing hospital-based services. Changes in the standard sector were less drastic and included sectorisation, an increase in the number of community-based nursing and occupational therapy staff (from three to seven). Limited GP liaison was introduced.

Table 4 Differences between intensive (Nunhead) and standard (Norwood) services post-intervention

Service characteristics	Intensive service	Standard service
Interventions	Wide range	Standard
Patients on CPA	136	151
Community staff	4.7 medical, 15.8 nursing, 3 occupational therapy	2.5 medical, 6 nursing, 1 occupational therapy
Community nursing grades	Low	High
Staff turnover (one year)	33%	6%
Hospital beds	16	19
Admissions per 100 000 per annum	765	664
Length of stay	23 days	23 days
Day places	~30	~30
Non-hospital residential provision	7 places (respite)	—
Opening hours	Extended, on-call	9 am–5 pm weekdays

CPA, Care Programme Approach.

Table 5 Comparing intensive (Nunhead) and standard (Norwood) services

Intensive service	Standard service
2 teams	1 team
Non-hospital and hospital beds	Hospital beds
Crisis intervention focus	No crisis focus
More staff	Fewer staff
Dramatic change	Some change

CLINICAL IMPLICATIONS

- The intensive sector had two teams for acute and continuing care, the standard sector had one generic community mental health team.
- There were complex differences between sectors with more non-hospital services in the intensive sector.
- Overall change in services was more marked in the intensive sector.

LIMITATIONS

- Pre-intervention services in the two sectors differed.
- Implementation of community services, in the intensive sector, was incomplete.
- Both sector services were evolving throughout the study period.

Table 4 highlights differences between the two services during the intervention phase of the study, and Table 5 compares them with respect to some basic service characteristics. Differences in staff (more community staff in Nunhead), nursing grade mix (higher grades in Norwood), the range of interventions (wider in Nunhead), availability of non-hospital residential services (only in Nunhead), opening hours (extended in Nunhead) and staff turnover (higher in Nunhead) are noteworthy. On the whole, the implementation of Nunhead sector mental health services implied dramatic change, whereas changes in the Norwood service were less marked, but still significant and in line with changes in mental health service provision in the country at large. Table 6 shows ratings of the key consultants involved in the two services of how they thought services matched principles laid out in documents by MIND (1983) and the Royal College of Psychiatrists (1990). These ratings show that services in the Nunhead sector were considered to be less well adapted to the needs of people in the community with severe mental illness at the outset of the study but had undergone drastic change in the raters' view by the time of the follow-up stage (Time 2) of the study. There had been parallel, less dramatic change in the Norwood sector, too.

THOMAS BECKER, MD, Section of Community Psychiatry (PRiSM), Institute of Psychiatry, London; FRANK HOLLOWAY, FRCPsych, Maudsley Hospital, London; PAUL McCRONE, MSc, GRAHAM THORNICROFT, MRCPsych, Section of Community Psychiatry (PRiSM), Institute of Psychiatry, London

Correspondence: Frank Holloway, Community Directorate, Bethlem & Maudsley NHS Trust, 101 Denmark Hill, London SE5 8AZ

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Table 6 How well did services match principles? Consultant psychiatrist ratings (Royal College of Psychiatrists, 1990; MIND, 1983)

Principle	Intensive sector		Standard sector	
	Rating pre-intervention (1991)	Post-intervention (1996)	Rating pre-intervention (1991)	Post-intervention (1996)
Special needs	●●	●●●	●●	●●
Local	●●	●●●	●●	●●●
Comprehensive	●●	●●●●	●●	●●●
Flexible/choice	●	●●●	●●	●●
User oriented	●	●●●	●	●●
Empowerment	●	●●●	●●	●●●
Culturally appropriate	●	●●	●	●●
Strengths/skills focus	●	●●●	●●	●●●
Most natural	●	●●●	●●	●●●
Accountability	●	●●●	●	●●●
Sum score	13	30	17	26
Pre-post change		17		9

● principle not matched, ●● moderately matched, ●●● reasonably matched, ●●●● excellently matched.

THE COURSE OF SECTORISATION

Changes in the course of sectorisation of mental health services in the two areas could be described as coming close to a 'revolution' in Nunhead (intensive sector), while the process was 'evolutionary' in Norwood (standard sector). The process of sectorisation occurred under considerable financial pressure which meant that sources of funding had to be shifted rapidly and in a major way in order to fund the community teams. In the case of beds there was, in fact, a drastic reduction in Nunhead bed numbers early on when community teams were set up, which had to be redressed at a later stage. It is, therefore, important to bear in mind that both services were evolving during the

study period and had not reached a stable equilibrium at the time of the Time 2 interviews. Therefore, the intervention described might well warrant further description and a third wave of interviews at a later point in time.

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